Tower Health Urgent Care
Advancing Health. Transforming Lives.

Employer Authorization Form

Information identified with * is required

***Patient Name:** _____ ***SS#** ___ - ___ - ____ ***Date:** _____

***Company:** _____ ***Phone:** (___) _____

***Company Address:** _____

***Primary Contact (Name and Title):** _____ Tower Health Location: _____

Please provide the above patient with the following services: (please check all that apply)

Drug Screen Testing
- ☐ 10 panel rapid drug screen
- ☐ DOT urine drug screen, 5 panel w/ MRO review
- ☐ Non DOT urine drug screen, 10 panel drugs of abuse
- ☐ UDS collection only (COC provided)
- ☐ Rapid saliva alcohol test

Office Testing
- ☐ Audiology
- ☐ EKG
- ☐ Pulmonary function test (may need chest X-ray if abnormal)
- ☐ Respirator fit test
- ☐ PPD (Tuberculosis Screen)

Physicals
- ☐ Pre-Employment /Annual Physical Exam
- ☐ DOT/non DOT Commercial Drivers License (CDL)
- ☐ OSHA respirator clearance w/ medical surveillance physical
- ☐ OSHA respirator medical surveillance questionnaire
- ☐ School bus driver physical
- ☐ Firefighter Physical (NFPA 1582) –Company contract

Radiology
- ☐ Chest X-ray
- ☐ Lumbar Spine

Laboratory Testing
- ☐ Comprehensive blood count
- ☐ Comprehensive metabolic profile
- ☐ Lipid panel
- ☐ Urinalysis

Vaccines
- ☐ Hepatitis A, per dose (immunity = 2 doses) ☐ dose 1 ☐ dose 2
- ☐ Hepatitis B, per dose (immunity = 3 doses) ☐ dose 1 ☐ dose 2 ☐ dose 3
- ☐ Flu vaccine
- ☐ Tetanus

Workers Compensation
- ☐ Worker's Compensation Injury Treatment:
  Date of Injury:_____ Type of Injury:_____
- ☐ Post-accident 10 panel rapid drug screen

Preferred communication for clinical results:
☐ Phone(___) _____ ☐ Fax (___) _____ ☐ Email _____

REQUIRED FOR ALL WORKER'S COMPENSATION CLAIMS:

Has Employer filled out First Report of Injury? ☐ Yes ☐ No (if yes, please send copy with employee)
Where are claims to be filed? ☐ Employer ☐ Carrier
W/C Carrier: _____ Policy #: _____
Address: _____ Phone: (___) _____

EMPLOYER AUTHORIZATION:

By signing below, I authorize the treatment for the employee specified above for the services indicated in this form. I hereby attest that the above information is accurate and complete to the best of my knowledge. I understand and agree that I, the employer, will be financially responsible for any and all WC charges in the event that the WC Benefits are denied by the above specified carrier. I further authorize the employee information to be accessed by all Tower Health Urgent Care clinics to provide continuity of care. This information includes, but is not limited to: diagnoses, prescriptions, treatment plans, lab results, referrals, and x-ray reports.

_____ _____
Signature of Authorized Company Representative *Date*

_____ _____
Printed Name *Position/Title*